24. There were two consultants in the Urology unit in CAH, Mr. Aidan O'Brien and Mr. Michael Young. Whilst I had met both of them before at educational events, I had not worked with either of them previously.

25. The Urology department in CAH at that time had its own inpatient ward. I cannot remember precisely, but there were probably around 20 beds on the CAH Urology ward. The ward would have been fully staffed by nurses on a 24/7 rotation. At the time there would have been a ward sister and deputy ward sister for the Urology ward. The consultants were supported by a number of nurse specialists; nurses who specialised in Urology, having had additional urology training.

26. I was the only Urology Specialist Register in CAH during my rotation, but there were a number of other junior grade medical staff (Senior House Officers and Junior House Officers) also there at the time. Like specialist registrars, they will also have changed over time on rotation. My recollection is that the CAH Urology unit was busy with good training opportunities.

27. Whilst Mr. O'Brien and Mr. Young had their own sets of urology patients, they did do a joint Thursday morning ward round together. I attended this. It meant they were involved with each other's patients. They would also have covered for each other, seeing each other's ward patients, on the weekend rotations and for holidays.

28. I have reflected over time, arising from the questions posed by the USI in the section 21 notice, about the 6 months I spent in CAH. As I have done so, I have recalled that there were a number of situations that arose that caused me to feel concerned about some of the practices of Mr. O'Brien. With the passage of time it is not now possible for me to recall all the details. I did not keep a formal record at the time. I am afraid it would not have occurred to me to do so. I did raise issues that concerned me with Mr. O'Brien himself, and also with Mr. Young about Mr. O'Brien, during my 6 months rotation. In 2000 that would have seemed like a brave or courageous step from a higher surgical trainee. I am sure I probably saw it that way at the time. Whereas, with all the more recent and ongoing changes in medical culture (transparency, openness, and the many mechanisms for raising concerns) and the development of clinical governance (introduced into health and social care around 2003), it hardly seems

that this had happened but was concerned that perhaps something would be said to me for having discharged the patient in the first place. Mr. O'Brien never mentioned it to me. As I reflect on this now for the purposes of this statement, I realise that was an unusual practice that was occurring.

IX. **Administration delays.** As I reflect on Mr. O'Brien's administrative processes, having subsequently had many years in practice myself, it would be fair to say that I look back on Mr. O'Brien's administrative processes as appearing disorganised and chaotic. I accept it may have been a symptom of his workload, but his office was always full of patient charts awaiting dictation which, as I recall, often took a considerable time to process. His secretary would complain about it. The delays were probably compounded by what I now, with hindsight, consider to be his tendency to over investigate patients. However, he also wrote what seemed to me to be extremely long letters, which often seemed to struggle to get to the point. This will have added to the turnaround time. It is of course easy to criticise the practice of others, but it is obviously important, when writing letters to GPs, that they are timely, and that the diagnosis and management plan is succinct and clear.

Raising concerns as a trainee

32. As I have indicated earlier in this statement, I did raise issues with Mr. O'Brien about his practice during my time as a surgical trainee in Craigavon Area Hospital. Mr. O'Brien did not agree with me and was essentially dismissive. I did also raise issues about Mr. O'Brien with his Consultant colleague, Mr. Young, during my rotation. This would have been in an informal manner, and I would not have recorded them in written form. It just would not have occurred to me at the time to do that. It means that I cannot now say precisely what I raised with Mr. Young, or how I precisely I said it. My recollection was that Mr. Young's response to what I said was "that's just Aidan". Mr. Young did not give me the impression that he had any major concerns about the matters I was raising. I don't know if Mr. Young spoke to Mr. O'Brien about any of them, or if Mr. Young spoke to anyone else about them. I certainly thought at the time that I was brave in speaking to both the consultant himself, and to his consultant colleague. In my experience, it certainly was very unusual for trainees in 2000 to raise concerns about consultants and their practice. There were a number of reasons for

And when I did raise concerns with Mr. Young, as I've said in my statement, his response was "That's just Aidan". **[TRA-07907]**

Having regard to the evidence above, you are now asked to address the following:

(a) Do you recall any occasions on which Mr Hagan spoke to you regarding concerns? Please provide full details of all such discussions.
(b) Do you recall others having shared concerns with you in respect of the various issues described by Mr Hagan in his evidence?
(c) To the extent that it is your evidence that you do not recall such interaction with Mr Hagan, please clarify whether it is your evidence that: (i) you do not recall any such interaction or (ii) that no such interaction occurred.

1.01 (a) There is always the expectation that a registrar, as part of their training, will inquire about care-pathways for patients. For instance, I recall that Mr Hagan would have discussed prostate cancer management with Mr O'Brien on ward rounds. However, I did not ever interpret this as a concern and I do not recall Mr Hagan, during his six-month attachment, ever raising any serious issues because I would have acted upon them.

1.02 (b) I do not recall anyone else raising the points he comments upon.

1.03 (c) I do not recall any occasions when Mr Hagan raised the concerns mentioned.

2. At WIT-98846, Mr Hagan describes his concerns in respect of benign cystectomy being performed on a young woman:

'There was a young woman, in her early 20s, who had this procedure before I arrived to do my rotation at CAH, but who then had subsequent admissions for fluids and antibiotics during the time I was in CAH … The young woman made a lasting impression on me as she was really miserable, especially as she was continuing to have UTIs notwithstanding the major operation she had been put

time point if there is bleeding or if a little extra time is required to complete the procedure.

3.2 I am aware Mr O'Brien could on occasions perform TURP for more than an hour, however, I was not aware of the duration mentioned by Mr Hagan. It is likely that all Units will have examples of TUR Syndrome but I am not aware of Mr O'Brien having a higher incidence of TUR Syndrome than anyone else.

(b) Do you recall this issue being raised with you by Mr Hagan? If so, please provide full details of all discussions with Mr Hagan.

3.3 I do not recall a precise conversation on this case as it was 23 years ago, however, if Mr Hagan had raised an issue such as this I would have asked him had there been TUR Syndrome with this patient.

(c) Do you recall responding to Mr Hagan in the manner he has suggested?

3.4 With regards to the phrase "that's just Aidan", it is a phrase that I, as well as others, would have used in general terms. However, it certainly would not have been a phrase I would have used when responding to someone commenting upon a TURP of that duration.

(d) To the extent that it is your evidence that you do not recall such interaction with Mr Hagan, please clarify whether it is your evidence that: (i) you do not recall any such interaction or (ii) that no such interaction occurred.

3.5 I do not recall any such interaction regarding the TURP case that Mr Hagan has raised.

sufficient by today's standards when the opportunity for trainees to raise concerns are much more organised and available, and their use encouraged. Trainees are now heard and listened to in a way they would not have been in 2000.

29. As I have reflected on my time in CAH for the purposes of providing this statement it is possible to broadly identify 9 areas of concern that I address below. I would not have counted them up at the time in order to regrade them as some form of accumulation, and would not have had the "slow time" thinking about them facilitated by the questions posed by the USI. It is difficult for me to say whether the concerns I now identify, as I reflect back with hindsight, and with awareness of investigations into Mr. O'Brien, were concerns considered by me to be of the extent and nature that I now see them, and I would ask the USI to bear that in mind. It is also the case that how I responded to the matters that concerned me in 2000 would be different from how I would respond to them today, if I were still a trainee, including because the available mechanisms for responding are significantly different.

30. I should also say at the outset that I recognise and acknowledge that Mr. O'Brien was someone, in 2000, who was a senior consultant. He appeared popular with patients, pleasant to staff, and someone who worked hard (including into the evenings). I also acknowledge him assisting me to secure the opportunity to focus on a particular specialism I was interested in when training in Dublin in 2021.

31. The concerns were as follows:

I. **Patients being admitted to the ward for prolonged intravenous fluids and antibiotic therapy.** There was a group of patients that seemed to me to be being regularly admitted to the ward for antibiotics and IV fluids by Mr. O'Brien. My recollection is that these patients would make contact with Mr. O'Brien in some way and be admitted directly to the ward as an inpatient for treatment. When I asked about this practice the ward nurses referred to this treatment as "*Mr. O'Brien's regime*". I would do an unaccompanied ward round every morning during my 6 months rotation when I would come across these patients. It was often not clear to me the reason for this approach, or the evidence base for the treatment. I considered patients who fell into this category could have been managed as

63.1 My first awareness that the Trust had issues of concern regarding Mr O'Brien was in 2009 when Mr O'Brien was admitting patients, who had a chronic history of urinary tract infections, on an elective basis for Intravenous antibiotics and fluids. (It should be noted that I also admitted patients for intravenous antibiotics but they either had infections present or were symptomatic). The Medical Director at the time, Dr Loughran, commissioned an external review of this practice. This resulted in the elective admission of these patients stopping, with a new Trust pathway being put in place. ***(Relevant documents located at***

Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/20090512_Ltr_AO'brien_PLtc

20090518_letter to AOB, 20090602_ltr_AO'brien_ptc, - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090518_letter to AOB

20090717_ltr_AO'brien_urologypatients_PLlw, - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090602_Ltr_AO'Brien_PLtc, 20090717_Ltr_AO'Brien_UrologyPatients_PLlw

20090804_meeting re urology clinical practice, supplied by Trust E.S) - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090804_Meeting re Urology Clinical Practice

63.2 An incident on a ward round related to the inappropriate disposal of a patient series of fluid balance charts. This was reported by the Ward Sister, Shirley Tedford, to the Head of Service, Mrs M Corrigan. This resulted in Mr R Brown, Clinical Director for Surgery and Urology at that time, meeting with Mr O'Brien to discuss the matter and an informal warning being given at the time. The discussions relating to this issue having been accepted, resolved. The warning had time expired by the time I had undertaken Mr O'Brien's 2011 appraisal in April 2013 ***(Relevant document located at Relevant to MDO/evidence uploaded December 2021/no 77appraisals/20110101 Appraisal A'OB).***

Southern Health and Social Care Trust

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. **Demand & Capacity**
   Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

   Action
   - Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

   - Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. **<u>Quality & Safety</u>**

   <u>Key Issues</u>:-

   1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Key points from discussions with Dr Mark Fordham

Date 02 12 09

1 These cohorts of patients are difficult to manage

2 They have normal life expectancy (non cancer patients)

3 They can become psychologically dependent on hospital services in the absence of clinical need for services.

4 Proven UTIs may be best managed with Antibiotics. Where no pure growth is identified or urine cultures are from bowel based urine reservoirs, urine sampling needs to be interpreted with care.

5 Their current regimes do not have a scientific evidence base.

6 There is no need to treat patients who are able to drink normally with IV fluids

7 There are other more appropriate antibiotic regimes available.

8 Care can be provided with the support of primary care using various other treatments relating to out patient antibiotic regimes.

9 They will require unplanned admissions at different times for different reasons and proven indications including acute episodes of urology care

TRU-259410

Heather
Wo meets

Stinson, Emma M

From: Rankin, Gillian
Sent: 06 July 2010 18:34
To: Stinson, Emma M
Subject: FW: IV Antiobiotics IV Fluids update
Attachments: Patients who attend for IV Fluids.doc

From: Corrigan, Martina
Sent: Tuesday, July 06, 2010 6:34:27 PM
To: Rankin, Gillian
Subject: IV Antiobiotics IV Fluids update
Auto forwarded by a Rule

Dear Dr Rankin,

Please see attached update on IV Fluids and Antibiotic recent admissions. I checked with Shirley if any of these had involvement from bacteriology and she has advised:

These are the routine elective patients who are admitted and treated prophylactically irrespective of positive or negative culture results. To my knowledge the Consultants have not discussed ant of them with Dr Damanis team.

I hope this is the information that you need.

Kind regards

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

07/07/2010

Southern Health and Social Care Trust

Medical Directorate

Memorandum

Our ref:	PL/lw	**Your ref:**	
To:	Dr Gillian Rankin, Interim Director of Acute Services		
From:	Dr Patrick Loughran, Medical Director		
c.c.	Mr Eamon Mackle, AMD for Elective Care/Surgery Division, Acute Roberta Wilson, Governance Lead		
Date:	2nd September 2010		
Subject:	Urology Services		

Dear Gillian

Since the end of March 2009 the Trust has been examining the practice of IV antibiotic and fluid therapy as a prophylaxis for recurrent UTI's. I have received expert advice from Mr Mark Fordham (an acknowledged expert from Manchester) and Dr Jean O'Driscoll Consultant Microbiologist in Stoke Mandeville Hospital.

As a result of the expert external opinions and following several meetings and related correspondence with Mr O'Brien and Mr Young, I met with the 2 Urologists on 4th August 2009. During this meeting the surgeons agreed:

a) to compile an accurate list of patients who were on the IV programme
b) that each surgeon would review the treatment regime for each patient
c) that a multi-disciplinary group would be convened to look at a treatment plan for each patient. The core of this treatment plan would be to convert the patient from IV to oral therapy or another non-intravenous treatment (review/watchful waiting ??).

On 7th August 2009 Dr Damani and I agreed that he would provide Microbiology support for point's b and c above.

In the intervening period I understand that there has been a significant reduction in the number of patients within the cohort. I had expected that the number of patients would be extremely small by now and that the patients with central venous lines or long peripheral lines would have had the lines removed. You, Mr Mackle and I met on Wednesday 1st September 2010 and discussed the progress of this matter.

It is of concern to me that the agreement as set out above has not been followed by Mr Young and Mr O'Brien. In particular I understand that there are at least 7 patients remaining on the IV treatment and that 2 (and possibly 3) have permanent intra venous access. We agreed that Mr Young and Mr O'Brien should be informed of the meeting on Tuesday and should also be informed that I remain concerned that <u>any</u> patient is receiving this intra venous treatment.

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 15 June 2011 16:33
To: O'Brien, Aidan; [redacted]'; Rankin, Gillian; Walker, Helen; Trouton, Heather
Subject: Antibiotics and Urology Patients

Dear Aidan

I am seriously concerned that you don't seem to recall our conversation at the meeting last thursday. At that meeting I informed you that if you wanted to admit a patient for pre-op antibiotics or for IV fluids and antibiotics that a meeting had to be held with Sam Sloan and a microbiologist and that this prerequisite was non negotible. You have also been given this in writing following a previous meeting with Dr Rankin and myself.
I now find that you initially planned to admit a patient this week without having discussion with anyone and then when challenged you only spoke to Dr Rajesh Rajendran.
Would you please provide me with an explanation by return.

Eamon Mackle
AMD

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 30 January 2012 15:08
To: Stinson, Emma M
Subject: FW: IV Antiobiotics

From: Mackle, Eamon
Sent: Monday, January 30, 2012 3:08:01 PM
To: Hall, Sam
Cc: O'Brien, Aidan; [redacted]; Corrigan, Martina; Rankin, Gillian
Subject: IV Antiobiotics
Auto forwarded by a Rule

Dear Sam,

I have been advised that a patient [redacted] may have been admitted last week to Urology by Mr O'Brien and under his instruction was given IV Antibiotics the latter necessitating a central line to be inserted.

I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics.

I would be grateful if you could formally investigate this and advise me of your findings.

Many thanks

Eamon

Willis, Lisa

From: Trouton, Heather
Sent: 15 July 2013 09:02
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: For info: Antibiotic Ward round summary
Attachments: June summary UROLOGY.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Martina and Eamon

Please see below and attached.

Heather

From: Boyce, Tracey
Sent: 05 July 2013 11:18
To: Trouton, Heather
Subject: FW: For info: Antibiotic Ward round summary

Hi Heather
Mr O'Brian seemed to have another patient on gentamicin this month with no evidence of infection – I am sure Anne has the patient's details if you want to look at their reason for admission further.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

Personal Information redacted by the USI

From: McCorry, Ann
Sent: 05 July 2013 08:33
To: Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc: Corrigan, Martina; Trouton, Heather; Damani, Nizam; Boyce, Tracey; Muckian, Donna; Collins, Cathal
Subject: For info: Antibiotic Ward round summary

Hi All,

Please find attached the antibiotic ward round summary for June.

Kind regards
Ann

Ann McCorry

those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding Urology services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

47.10 There were a few operational issues like longer waiting times for urgent and elective cases, lack of beds, issues with theatre equipment.

47.12 On the clinical aspects there were some discrepancies in the practice of individuals in terms of choice and usage of antibiotics. For example, Mr Aidan O'Brien admitted a patient for administration of intravenous antibiotic just based on the symptoms. I do not recall the exact date or month. I directly discussed with him, during the joint ward rounds, about seeking the advice of microbiologist. He paid attention to my suggestion and acted accordingly. I recall Mr O'Brien contacting the microbiologist over the telephone on the same day and decided to withhold the antibiotic and to wait for culture reports. I cannot recall the exact date nor the details of the patient.

47.13 On the management aspects, there were some backlogs from Mr O'Brien in responding to online Advise & Guidance from GPs – not being replied in a timely fashion.

47.14 I highlighted these issues, whenever they arose, in the weekly departmental meeting and a consensus was reached. (The consensus in the departmental meeting was for all the consultants to adhere to the Trust Antibiotic Policy and every consultant to promptly respond to Advice & Guidance enquires from the GPs). **This can be located at S21 61 of 2022 Attachments, 7. Antibiotic guidelines UTI.**

47.15 Apart from the above and a few incident reporting, there was no need for me to escalate any issue beyond the clinical lead and the operational manager.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**
To address in a durable and effective manner my long inpatient waiting list, and in so doing, to reduce inequity in waiting lists.	These are Trust issues to be discussed and agreed.	2017
To address long waiting list for urological cancer reviews.		2017
To reduce the numbers of new patient consultations.		2017
Attend Course - urology	Enjoys Irish. Society meetg.	2016.

ANNUAL APPRAISAL 2010 MR. AIDAN O'BRIEN

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary:

Aidan qualified in 1978, holds full GMC registration and has been in the same Consultant Urologist post since 1992. He is a Fellow of the RCS in Ireland, and is a member of several general and urological societies. Description of his job reflects a broad urological practice. This includes MDM oncology involvement and a special interest in lower urinary tract dysfunction. Current rota is 1:3. The population base covered is geographically wide, and hence patients are from both urban and rural backgrounds.

A log of individual list of operations performed for 2008, 2009 and 2010 is impressively long, defining a constant and hard working pattern.

No formal complaints nor critical incidents are logged by the Trust. The Trust however has had discussions with reference to patients being treated with IV fluids and antibiotics. This has been satisfactorily concluded.

An audit of prostate biopsy outcomes is recorded. Several of the hospital mandatory courses have been attended.

Action agreed: For next appraisal

- log of total volume of outpatient activity, day cases and operations.
- audits in current time frame
- log Defence Organisation
- formally log mandatory courses

Southern Health and Social Care Trust

Interim Director of Acute Services
Administration Floor
Craigavon Area Hospital

27th September 2010 Ref: GR/pl/lw

Mr A O'Brien
Consultant
CAH

Dear Mr O'Brien

I am in receipt of correspondence in relation to 3 patients. In each case you have written to the patient, the General Practitioner and Mr Hagan Consultant Urologist in Belfast City Hospital.

Each of these patients has been transferred to the City Hospital for further management by Mr Hagan. I understand that you expected and wished to carry out this surgery yourself in Craigavon Area Hospital, but following contact from our Commissioner the Trust was obliged to refer the patients to Belfast.

It is of great concern that you have indicated to a patient, (in advance of a care pathway being agreed) your preferred management of the case. I believe that this puts inappropriate pressure on the receiving team and is regrettable. I understand that the transfer of these patients, with whom you may already have formed a good therapeutic relationship, was somewhat unexpected.

There is another difficult area which we are currently examining – the intravenous therapy (IVT) cohort. Since we have internal agreement that the future care pathway of these patients will be subject to a multi-disciplinary decision I do not want you to write to any of these patients individually. Any outcome of the multi-disciplinary team should be "signed off" by that team and only an agreed communication sent/provided to each patient.

Please acknowledge your agreement by return.

Yours sincerely

Personal Information redacted by the USI

Dr Gillian Rankin
Interim Director of Acute Services

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Fax No Personal Information redacted by the USI Email Address Personal Information redacted by the USI

FORM 6 - SIGN OFF

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE
None		**22 April 2014**

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			Yes
Quality improvement activity			Yes
Significant events review			Yes
Review of complaints and compliments			Yes
Feedback from colleagues	Year undertaken OR Planned Year:	2014	Yes
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	2014	Yes

Personal information redacted by the USI

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	Yes
Ensure the previous year's Personal Development Plan has been reviewed.	Yes
Forward required Forms according to the organisation's appraisal policy.	Yes

Personal information redacted by the USI

APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal

Personal information redacted by the USI

APPRAISEE

Signature of Appraisee: Date: 22 April 2014

APPRAISER

Personal information redacted by the USI

Signature of Appraiser: Name of Appraiser: Mr. Michael Young

GMC Number: Date: 22 April 2014

CO-APPRAISER (if applica

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____

Name: Aidan O'Brien	GMC Number: 1394911	Appraisal Period : 2012 & 2013

2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of Northern Ireland Cancer Network Site Specific Group in Urology External Assessor to the Royal College of Surgeons in Ireland for Specialist Registrar Appointments in Urology in Republic of Ireland
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Provision of expert medicolegal reports.

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

I have attached the proposed Job Plan which was to come into effect on 01 July 2011, and for a period of one year. This Job Plan provided for a total of 11.25 Programmed Activity sessions. Following facilitation in September 2011, the total number of Programmed Activity sessions was increased to 12.75 until 28 February 2012, reducing to 12 thereafter (letter attached). The current Job Plan (attached) was proposed to come into effect on 01 April 2013, providing for a total of 11.275 Programmed Activity sessions. However, that Job Plan was predicated on 5 Consultant Urologists in post, and which has only variously been the case since 01 April 2013. As a consequence, the initial job plan of 2011/12 remains in effect. However, that job plan has not been reviewed or amended to take account of changes in work patterns which have since developed, such as all day clinic sessions at South West Acute Hospital (rather than a half day) once monthly, extended inpatient operating sessions once weekly, and the additional work required in chairing Urology Multidisciplinary Team meetings.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Certificate of Completion of Discovering Diversity Programme	12 March 2014
2	GMC Colleague Feedback Report	25 February 2014
3	Multisource Feedback Structured Reflective Template	21 April 2014
4	Patient Feedback Questionnaire Report	March – April 2014
5	Patient or Client Survey Structured Reflective Template	21 April 2014
6	Advanced Communications Skills Training Course Certificate	29 June 2011 to 01 July 2011
7		
8		
9		
10		

Discussion

I believe that my relationships with my many colleagues of many disciplines, is at least satisfactory. Even though I have on occasion been outspoken in my views, particularly in relation to patient care, I have endeavoured to do so in a non-confrontational manner, and hopefully with minimal offense to others. I have found it increasingly difficult to keep apace with the expectation to respond to an ever increasing emailed communication, but continue to try. I have learned much in interpersonal relationships since becoming chair of MDM and of NICaN, learning how to ensure inclusiveness, how to arrive at consensus and to make progress on foot of consensus. I have completed the Discovering Diversity Programme. I have found the Colleague Feedback to be reassuring.

I believe that I am a good communicator with patients. I certainly invest much time in communicating with patients, because I enjoy doing so, and because I believe that it is the heart of the relationship between doctor and patient. It is the ability to communicate well, in both directions, that enables trust to be established. It therefore becomes a central part of the patient's management. While this pertains to all areas of clinical practice, it is particularly relevant in dealing with patients diagnosed with cancer. I found the three day, Advanced Communication Skills Training Course to be particularly relevant. I have found the Patient Feedback Questionnaire to be very reassuring.

Mobile: Personal Information redacted by USI

Email: martina.corrigan@ Personal Information redacted by USI

From: Trouton, Heather

Sent: 25 July 2011 15:07

To: Reid, Trudy; Devlin, Louise; Corrigan, Martina

Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha

Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them.

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by the USI lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for discharge tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4. DATE OF INCIDENT/ EVENT: 17 July 2018**
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 07 August 2019

8. SUMMARY OF EVENT:

Patient 92 was referred to Craigavon Area Hospital Emergency Department on 2 November 2017 by her GP for a productive cough, lethargy, sweats and back pain for 2 months. Patient 92 was admitted to the ward and treated for a urinary tract infection (UTI) and poor diabetic control. Patient 92 was discharged home the following day with a plan for an outpatient renal tract ultrasound scan (USS). Patient 92 had her USS on 16 November 2017 which reported further investigation was required to exclude renal malignancy.

Patient 92 had a follow up CT renal abdominal scan on the 28 November 2017. The CT scan reported that appearances most likely represented areas of renal inflammation, and likely infected renal cysts with probable abscess formation and that the appearances were not typical for underlying malignancy (cancer).

Patient 92 was contacted and advised to attend CAH ED for treatment of same. Patient 92 attended CAH ED and was admitted to the ward for treatment of an infected renal cyst. Prior to her discharge a follow up outpatient urology review appointment was arranged for 6 weeks and a repeat CT renal abdominal scan in 3 months' time.

Patient 92 never received a follow up urology outpatient review appointment. Patient 92 had a repeat CT scan on 13 March 2018 which reported a solid nodule suspicious of renal cell carcinoma. There was no follow up following CT report.

Patient 92 attended her GP on the 10 July 2018 complaining of right sided abdominal pain. Patient 92's GP noted the overlooked CT report and immediately forwarded a red flag urology referral to Craigavon Area Hospital.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER: Dr D Gormley, Consultant Physician	**10. TEAM MEMBERS PRESENT:** Ms W Clayton, Head of Service Mrs K Robinson, Booking & Contact Centre Manager Mrs C Connolly, Clinical Governance Manager

13. Why did it happen?

As part of the review process the chair of the review met with Patient 92 to discuss treatment and care prior to Patient 92's partial nephrectomy. Patient 92 advised that when she attended CAH with symptoms she felt staff did not listen to her concerns. Patient 92 believed her symptoms were more than a UTI and warranted further investigation at the time of presentation and not at a later date.

The review team reviewed Patient 92's first CAH ED attendance on 3 November 2017. The Review Team concluded treatment and care provided in CAH ED and on the ward was appropriate given Patient 92 presenting symptoms and the plan for an outpatient ultrasound scan was considered appropriate. The Review Team acknowledges Patient 92 had her ultrasound scan 13 days post discharge. This was considered by the Review Team an appropriate time frame for follow up.

The Review Team recognise the result of the ultrasound scan was appropriately followed up the following day by Dr 2 and arrangements were made for Patient 92 to have an urgent CT abdomen and pelvis scan to exclude renal malignancy on the 28 November 2017. The report was available the following day.

The Review Team identified Patient 92 was appropriately referred on to the cancer tracker system on the 23 November but unfortunately did not attend her appointment on 4 December 2017 due to her inpatient status under the care of the Urology Team.

The review team has reviewed Patient 92's medical notes from her admission on 29 November 2017 to her discharge on the 7 December 2017, and considers treatment and care during this period was appropriate. The Review Team recognises results were appropriately followed up by doctor 2 and appropriate arrangements were made for Patient 92 to re-attend CAH ED and to be admitted under the care of the urology team. Patient 92 was admitted to the Gynecology ward under the care of doctor 3, Consultant Urologist. Patient 92 was treated for an infected renal cyst with antibiotics. Patient 92 was discharged home with antibiotics on the 7 December 2017 with a plan to be followed up at Dr 3's outpatient clinic in six weeks and a follow up CT rena scar in three months' time. The Review Team has concluded a differential diagnosis of an infected renal cyst was appropriate following the CT report on 29 November 2017 and has therefore considered treatment and care, and discharge arrangements were all appropriate at the time.

The Review Team has reviewed the Patient Administration System (PAS) and confirmed Patient 92 was added to Dr 3's urgent urology outpatient waiting list following discharge on 7 December 2017. The Review Team acknowledges there are demand and capacity issues with Urology outpatient appointments, and waiting lists are extremely lengthy (currently 3 years). The Review Team acknowledge clinics are scheduled in advance, and recognise doctor 3's clinics may not have been scheduled that far ahead. With no outpatient clinic scheduled it would have being impossible for medical staff to ascertain Patient 92 would be appointed an outpatient appointment in six weeks' time. Patient 92 was therefore added to Dr 3's urgent urology waiting list which at the time had a waiting time of 96 weeks. Conversely, the Review Team concluded had Patient 92 been reviewed six weeks post discharge the management plan may not have changed given the recent CT scan result reporting an infected renal cyst and treatment received.

On 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The Review Team note the report was finalised on the 20 March 2018 at 14:05. The Review Team have confirmed communication was emailed to the referring Consultant Urologist Dr 3 and secretary 1 and an additional secretary 2 (secretary1 was off on leave) on the same day 20 March 2018 at 14:54. The email advised all correspondents an urgent report for Patient 92 was available on Sectra Radiology Information System (RIS). The Review Team have identified Patient 92's report was completed in a timely manner and escalated to the referring consultant immediately by the Radiology Team. The Review Team on the other hand cannot confirm Dr 3 read the report. Secretary 2 has advised the Review

Clayton, Wendy

From: Young, Michael
Sent: 14 September 2022 13:36
To: Haynes, Mark
Cc: Clayton, Wendy
Subject: RE: Results

Mark and Wendy

I only handed in my Inquiry report at the end of August and had a week away in England
I am now back in action today so you all will see more activity now.
Many thanks

MY

From: Haynes, Mark [Personal Information redacted by the USI] >
Sent: 14 September 2022 07:44
To: Young, Michael < [Personal Information redacted by the USI] >
Cc: Clayton, Wendy < [Personal Information redacted by the USI] >
Subject: Results

Morning Michael

Data relating to results requested in your name is summarised below. I am particularly concerned with the results that are in the red column. Once results are older than 7 weeks (from date of reporting) they disappear from your sign off list (and do not appear in this report once over 42 days from date of radiology report) and therefore there is a risk of them not being actioned. As you are aware, clinically significant incidents have been identified over the past 2 years relating to a lack of prompt action by clinicians with regards radiology results.

	Days since reported		
	0-13	14-27	28+
14/09/2022	10	6	7
07/09/2022	10	9	4
31/08/2022	20	12	2

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 07 February 2016 21:22
To: Corrigan, Martina; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: RE: Standard Operating Procedure for Fluid Management during Urology surgery

Dear All,

I suspect that any comments from me will be perceived to have been prejudicial.
However, I honestly did approach using the much hailed Olympus with a view to giving it a fair wind.
And was I bowled over?
No!
I resected two small prostates.
I found it deficient in two respects:

1. It is my understanding that there is no blended current on cutting with the result that haemostasis was inferior to monopolar during cutting
   You resect, it bleeds and you coagulate.
   This slowed the resection.
   It also had me wondering whether one would have increased fluid absorption as a consequence.

2. The rate of irrigation was much slower than with the monopolar resectoscopic, with the result that there was an intermittent fog which I had to stop resecting to wait for it to clear.

I was so glad that neither prostate was large, as I certainly would not have used the Bipolar.

The Audit asks the question whether the trialist would be 'happy' to use it.
My answer was a definite 'No'.
I will do if I have to.
I just do hope that the Operating procedure will allow me to continue to use Monopolar, as it is very much superior,

Aidan

From: Corrigan, Martina
Sent: 07 February 2016 17:55
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Standard Operating Procedure for Fluid Management during Urology surgery

Any comments?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 30 March 2016 16:17
To: Young, Michael; Corrigan, Martina
Cc: Glackin, Anthony; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP
Subject: Bipolar Resection

Michael and Martina,

I wish to take the opportunity to update you on my experience of trying bipolar resection systems.
I have tried the models on trial to date, and did so having disabused myself of any prejudice against their use.
As reported previously, I found their performance inferior to monopolar mainly as a consequence of the intermittency of the current, the lack of any small vessel fulguration whilst cutting and the much reduced rate of continuous irrigation.
I last use bipolar two weeks ago to resect the moderately enlarged prostate gland of an elderly patient.
I had to abandon bipolar resection after 10 minutes because of bleeding, poor irrigation and visualisation.
The intraoperative comparison of both systems was remarkable.
Bipolar resection placed this patient in intraoperative danger, and salvaged by monopolar resection.

I have therefore pledged not to do so again.
I will not use or try bipolar resection again,

Aidan.

	Acute Governance Report Sept17.doc	
4.0	**Complaints** • Trends – There continues to be a general increase in complaints, MLA enquiries • There is a slight increase in outstanding complaints, efforts continue to address complaints • Reopened report available for information and action as required Complaints comparison 2014 -20; complaints and enquiries by month 2(; Weekly Re-Opened Report 160817.xlsx; Current Complaints 060917.xlsx	**AD's**
5.0	**Ombudsman Cases** • Report discussed – there are no outstanding queries – we await response from the ombudsman in relation to 13 live cases Ombudsman weekly 010817.xlsx	**Trudy Reid**
6.0	**Directorate Risk Register** • Divisional risk register reviewed, risks to be removed and updated • Equipment risks to be added Directorate RR July17.xlsx; CCS Divisional RR July17.xlsx; FSS Divisional RR July17.xlsx; IMWH Divisional RR July17.xlsx; MUC Divisional RR July17.xlsx; Pharmacy RR July17.xlsx; SEC.ATICS Divisional RR July17.xlsx	**Trudy and AD's**
7.0	**SAIs:** • Summary report- screening on going, many reports reaching completion, however due to summer leave they are slight delays finalising the reports • SAI Recommendation – report available for information and action planning SAI Position Report 04092017.xlsx; SAI Recommendations 9.(	**Trudy & AD's**
8.0	**Incidents** • Summary report- available for information and action as required • Major and above – discussed- most will be down graded Major and Catastrophic Incident; Incident Review Position as at 040917 **Absconding patients** • report- available for information and action as required	**AD's**

6.8 I personally discontinued the use of glycine when the new resectoscope system was on site.

(g) Were you aware of others continuing to undertake these procedures beyond this point?

6.9 I understood that the other Urologists had also changed to using the saline system. I was however aware that Mr O'Brien did not like the saline system as he regarded it as an inferior system. I personally thought he needed a further period of time to get used to the saline system. It has only come to my knowledge recently that he never did convert to using saline and continued to use glycine. *See:*

15. 20160207 E from AOB Re SOP for Fluid Management during Urology Surgery

16. 20160330 Response from AOB re Bipolar Resection

(h) What was your view on the introduction of bipolar resection with saline? Did you believe it to be a suitable alternative? Why/ why not?

6.10 I regarded the TUR with saline as a suitable alternative. It required a slight adaptation to the surgical technique. The cut and coagulation mode I thought were not as good as with glycine, but it only took a little time to adapt. The advantage of a safer system was paramount. It was clear to me that saline was a safer modality to use.

(i) Was training required to adapt to the new equipment and technique? If yes, please provide details of all such training you received.

6.11 The basic technique was the same as the previous system. The representatives from the companies supplying the equipment explained what they noted other surgeons had commented upon and this was adequate to enable me to adapt my technique. There is an element of self-learning (as there is with all surgical techniques) which was all that was required. I personally felt there was a fairly short learning curve.

5.0 IMPLEMENTATION OF POLICY

This policy, after it is agreed, is to be implemented throughout NI in each of the 5 Trusts.

5.1 Resources

There will be resource implications in terms providing surgical equipment that can be used without needing glycine as an irrigant, fluid flow and pressure controllers and POCT monitoring equipment for theatres and training for staff.

6.0 MONITORING

Trust audit departments will need to monitor that the recommendations are implemented.

7.0 EVIDENCE BASE / REFERENCES

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3. Practice Committee of the AAGL Advancing Minimally Invasive Gynaecology Worldwide. Practice Report: Practice Guidelines for the Management of Hysteroscopic Distending Media. Journal of Minimally Invasive Gynaecology (2013) 20, 137–148.
4. Gravenstein D. Transurethral Resection of the Prostate (TURP) Syndrome: A Review of the Pathophysiology and Management. Anesthesia & Analgesia. 1997; 84: 438-46.
5. S. Gravas, A. Bachmann et al. European Association of Urology April 2014. Guidelines on the Management of Non-Neurogenic Male Lower Urinary Tract Symptoms (LUTS), incl. Benign Prostatic Obstruction (BPO).
6. Marszalek M, Ponholzer A et al. Transurethral Resection of the Prostate. European urology supplements 8 (2009) 504–512.
7. Mamoulakis C, Ubbink DT et al. Bipolar versus Monopolar Transurethral Resection of the Prostate: A Systematic Review and Meta-analysis of Randomized Controlled Trials. European Urology 56 (2009) 798 – 809.
8. Michielsen DPJ, Coomans D et al. Bipolar transurethral resection in saline: The solution to avoid hyponatraemia and transurethral resection syndrome. Scandinavian Journal of Urology and Nephrology, 2010; 44: 228–235.
9. Omar MI, Lam TB, Alexander CE et al. Systematic review and meta-analysis of the clinical effectiveness of bipolar compared with monopolar transurethral resection of the prostate (TURP). BJU Int 2014; 113: 24–35.
10. NICE Lower urinary tract symptoms: Evidence Update March 2012. https://www.evidence.nhs.uk/evidence-update-11
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14. Black P. Bladder Tumour Resection: Doing it Right. Journal of Urology; 191: 1646-47.
15. Lethaby A, Penninx J, Hickey M et al. Cochrane Collaboration review (2013) Endometrial resection and ablation techniques for heavy menstrual bleeding (Review).
16. NICE. Treatment options for heavy menstrual bleeding - pathway. April 2014.
17. Personal Communication.
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19. Loffer FD, Bradley LD et al. Hysteroscopic Fluid Monitoring Guidelines. Journal of the American Association of Gynecologic Laparoscopists. 2000; 7: 167–168.

TURP Audit (2019)

Introduction

Do we know whether AOB did, in fact, use the bipolar equipment or did he continue to use monopolar in glycine, as his emails at TRU-395976 and 395978 suggest was his intention?

The TURPS equipment was purchased for the Urology Department in January 2018 and put into circulation in April 2018. Therefore it was felt that the best period to look at, and determine did Mr O'Brien use this equipment was January – December 2019 and to ensure equity this audit included all consultant urologists.

Identifying Patients

The Trust's information Team were contacted, (reference 10629 -1023) to request patient details based on Inpatient Finished Consultant Episodes and Daycases (Elective and Non-Elective) that had a TURP procedure performed as either a primary or a secondary operation, using the following codes:

M65 **Endoscopic resection of outlet of male bladder**
Includes: Endoscopic resection of lesion of outlet of male bladder
Transurethral resection of prostate
Note: It is not necessary to code additionally any mention of diagnostic endoscopic examination of bladder (M45.5, M45.9)
Use a subsidiary code for robotic assisted minimal access approach to body cavity (Y76.5)

M65.1	Endoscopic resection of prostate using electrotome
M65.2	Endoscopic resection of prostate using punch
M65.3	Endoscopic resection of prostate NEC
M65.4	Endoscopic resection of prostate using laser
M65.5	Endoscopic resection of prostate using vapotrode
M65.6	Endoscopic ablation of prostate using steam
M65.8	Other specified
M65.9	Unspecified

The Trust's information Team sent a spreadsheet with this information on 9 October 2023. In total, 121 patients had a TURP done during 2019. 117 patients were done electively and 4 were done as an emergency. There were no daycase TURP's.

Totals for each Consultant and sample picked for audit (Mr O'Brien had the majority of the operations for TURP so double the sample looked at).

Consultant	Elective	Emergency	Total	Total Charts requested
Mr Glackin	12	1	13	5
Mr Haynes	6	0	6	5
Mr O'Brien	57	1	58	10
Mr Tyson	4	0	4	4
Mr O'Donoghue	21	0	21	5
Mr Solt	4	1	5	5
Mr Young	13	1	14	5

Audit Methodology

Patient's Operation Notes, Theatre/Recovery Pathway and Theatre Fluid Balance notes were audited and comments recorded on a spreadsheet (Attached – 2019 TURP Audit Summary).

Findings

Consultant	Bipolar or Monopolar	Glycine or NaCl - Sodium Chloride	Comments
Mr Glackin	3 x bipolar 2 x Greenlight Laser	3 x sodium chloride 2 x n/a	
Mr Haynes	4 x bipolar 1 x monopolar	5 x sodium chloride	Mr D Hennessy was operator for one of Mr Haynes patients
Mr O'Brien	9 x monopolar 1 x bipolar (JOD)	7 x glycine 2 x monopolar had no fluid balance in notes 1 x sodium chloride (JOD operator)	Mr O'Donoghue was operator for one of Mr O'Brien's patients
Mr Tyson	4 x bipolar	4 x sodium chloride	
Mr O'Donoghue	5 x bipolar	5 x sodium chloride	
Mr Solt	4 x bipolar 1 not stated (AOB operator)	3 x sodium chloride 2 x no fluid balance in notes (1 x AOB)	Mr O'Brien was operator for one of Mr Solt's patients
Mr Young	3 x bipolar 2 waiting on notes	3 x sodium chloride 2 waiting on notes	Mr D Hennessy was operator for one of Mr Young's patients

Conclusion

All of the consultants moved to Bipolar with Sodium Chloride apart from Mr O'Brien who continued to use Monopolar and Glycine.

O'Brien engaged in the process of assessment of new bipolar resection equipment. However, he subsequently expressed the view that he would be continuing to use monopolar resection in glycine, thereby not conforming with the policy. On reflection, this unwillingness to conform with recommendations from others should have provoked concern regarding wider aspects of his practice, especially with regards to delivering treatment in line with NICE guidance / MDM recommendations. *Please see 7. 20181205 E re Transperineal Prostate Biopsy Equipment, 8. 20171120 E re Saline TUR, 9. 20171120 E re Saline TUR A1, 10. 20171120 E re Saline TUR A2, 11. 20171120 E re Saline TUR A3 and 12. 20171120 E re Saline TUR A4.*

69.11 Previously, concerns regarding the clinical decision making relating to emergency admissions were raised within the consultant urology team regarding a former consultant colleague ([redacted]). I believe it was Mr O'Brien who raised this concern following an emergency re-presentation of a patient he had operated on. These concerns were also backed up by some concerns from other members of the consultant team regarding some emergency admissions. These concerns were raised with the consultant in question and additional support was provided in addition to the consultant attending some educational courses regarding emergency urology. *Please see 77. 20151217 - Confidential Meeting* [redacted].

70. ~~**64.**~~ **Did you raise any concerns about the conduct/performance of Mr O'Brien?**

If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr. O'Brien, why did you not?

Carroll, Assistant Director, with regards to the Trust investigating the substantial number of untriaged letters and misplaced patient records that had been in Mr O'Brien's house. We were asked to partake in an exercise to triage these outstanding referrals and to review the medical records to identify if there were any patients that could be at risk. Of those referrals I triaged, several were upgraded to Red Flag and I asked a colleague to verify if he agreed with my decisions. Some were clearly Red Flag referrals. I am also aware my colleagues also upgraded some referrals. All un-triaged referrals had the potential for patients to come to harm. During the look back exercise, I didn't see any GP coded Red Flag referrals among the un-triaged referrals, i.e., it seems the Red Flag letters were triaged. Red Flag referrals are usually printed on yellow paper to make them stand out. The hard copy GP referrals are on their standard headed white paper. It was not clear to me if Mr O'Brien had screened the routine letters. This exercise took several weeks ***(Relevant document located at S21 No 55 of 2022, 118. 20170103 E re informing Consultants).***

65.7 Following Mr O'Brien's return to work, I was made aware by Mrs Corrigan, Head of Service, that a stipulation for this was that triage by Mr O'Brien was to be completed by the end of the Friday after being on-call and this would be monitored by herself for Mr Carroll, Assistant Director.

65.8 The issue pertaining to private patients were discussed in the lookback exercise of early 2017 (see Q64). I have had no other conversations on this point that I can recall.

65.9 The SAIs leading to the Root Cause Analysis have only been available following Mr O'Brien retirement. In addition to the comments made in response to Q64 on this issue, I did become aware of the insufficient prescription dosage of the prostate medication around the time of Mr O'Brien's actual retirement date following a conversation with Mr Haynes.

65.10 Soon after Mr O'Brien retired, Mr Haynes informed me that several other cases relating to the prescription of the Casodex / Biclalutamide had come to light in addition to the delay in MDT referrals to oncology. He said the Trust was informing the DoH.

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 07 June 2017 18:25
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: undictated clinics
Attachments: OC 1.pdf; OC2.pdf; OC3.pdf; OC4.pdf; OC5.pdf; OC6.pdf; OC8.pdf; OC9.pdf

Hi Siobhan

To update on the findings from the undictated clinics:

There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he had returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow.

Katherine Robinson's team are currently recording the outcomes from these and these will all be backdated to when the clinics happened.

There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted and no further concerns. The other two have cancelled their appointments themselves and have been rearranged for beginning of July so I will keep an eye on these and make sure there is no more concerns.

Other comments made by the consultant were:

1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter
2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit
3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?
4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.
5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again
6. Patient seen on 11/04/16 but letter was dictated on 22/02/17.

If there is anything further in respect to this please do not hesitate to contact me

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

I may have assumed Martina Corrigan would do this because the emails were sent to her as well as to me. It may well be that, as with the issue of follow up with Mr Haynes in respect of the first email, this issue simply got side-lined because of other more pressing day-to-day work. The next time any private patient issue was raised *to my knowledge was at the meeting in January 2017 as part of the lookback exercise.'*

6. At paragraph 65.8 (WIT-51823), I have stated, '*I have had no other conversations on this point that I can recall.*' This should state, '*I have had* ***little in the way of*** *other conversations on this point that I can recall* ***other than at interview for the MHPS*** ***and as described at paragraph 64.15 above****.'*

Additional Material

7. I wish to provide the following additional information, not already included in the 'Mr O'Brien' (Q61 to Q74) section of the Section 21 Notice:

    a. When triaging on 30th July 2018, I observed in correspondence from the A&E department that the patient had seen Mr O'Brien and had recently been commenced on Desmopressin 200 micrograms. She had a subsequent admission with hyponatraemia in June 2018. Her hyponatraemia did resolve and correspondence from Mr O'Brien did acknowledge the relationship between the Desmopressin dosage and her hyponatraemia. On seeing this correspondence, I emailed Mr O'Brien to note that the correct dose of the medication for an elderly lady was 25 micrograms *(see 2. 20180730 -Email MY to AOB Desmopressin*). I thought he would appreciate this correspondence. On reviewing the situation, I note that the correct dose was recorded on a discharge comment of October 2018. My memory of this episode was only triggered in very recent times (when seeing another elderly patient potentially in need of Desmopressin). Having reflected on it, I acknowledge that an option open to me in 2018 would have been to complete an IR1 form. I

Corrigan, Martina

From: Young, Michael <Personal Information redacted by the USI>
Sent: 30 July 2018 10:40
To: O'Brien, Aidan

Aidan

Personal Information redacted by the USI

Triaging letters
Had a a/e attendance and we note an August r/v with yourself
I see she was on desmopressin at 200 microgram but got hyponataemia

The new Ferring drug Noqdirna is desmopressin 25 microgram for elderly females

MY

TRU-165621

Mr Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information
Submitted time (hh:mm)	14:56

Incident IR1 details

Notification email ID number	Personal Information
Incident date (dd/MM/yyyy)	01/08/2017
Time (hh:mm)	10:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient's wife contacted myself as they were expecting an appointment with oncology/surgery to discuss curative treatment for prostate cancer. Upon checking with Belfast, they had no record of a referral having been received.
Action taken Enter action taken at the time of the incident	Cancer tracker contacted and patient to be discussed at next MDT meeting. Patient's Consultant and Unit manager made aware.
Learning Initial	
Reported (dd/MM/yyyy)	01/08/2017
Reporter's full name	dolores campbell
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	04/08/2017
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 166

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Thorndale Unit
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	Outpatients
Speciality / Team	Outpatients

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Percival, Joanna Sr	Personal Information redacted by the USI	01/08/2017 14:56:34	Personal Information redacted by the USI		Department Manager
Reid, Trudy	Personal Information redacted by the USI	01/08/2017 14:56:34			Interim Assistant Director of Corporate Governance
Contact Personal Information not found	cathy.rocks Personal Information redacted by the USI	01/08/2017 14:56:33			
Contac Personal Information not found	caroline.moorcrof Personal Information redacted by the USI	01/08/2017 14:56:33			
Matthews, Josephine Mrs	Personal Information redacted by the USI	01/08/2017 14:56:33			Lead Nurse
Carroll, Ronan MR	Personal Information redacted by the USI	01/08/2017 14:56:32		Personal Information	Assistant Director of Acute Services
Clayton, Wendy	Personal Information redacted by the USI	01/08/2017 14:56:32			OSL
McAloran, Paula	Personal Information redacted by the USI	01/08/2017 14:56:32			Senior Governance Officer
ONeill, Kate	Personal Information redacted by the USI	01/08/2017 14:56:31			Ward Sister, Thorndale
McMahon, Jenny	Personal Information redacted by the USI	01/08/2017 14:56:31			Sister in Charge (Thorndale)
Contact Personal Information not found	dorothy.sharpe Personal Information redacted by the USI	01/08/2017 14:56:31			
Corrigan, Martina	Personal Information redacted by the USI	01/08/2017 14:56:31			Head of ENT and Urology

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate	

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.

Incident Details
ID & Status

Incident Reference ID	[redacted]
Submitted time (hh:mm)	13:43

Incident IR1 details

Notification email ID number	[redacted]
Incident date (dd/MM/yyyy)	17/05/2017
Time (hh:mm)	16:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at MDM 12th January 2017. Outcome = to be referred to endocrine MDM. Unfortunately this did not happen. Further GP referral 12/5/17 brought this to my attention and a referral has now been done.
Action taken Enter action taken at the time of the incident	Referral made to endocrine MDM on 17/5/17 (4 month delay). See ECR for relevant letters etc.
Learning Initial	
Reported (dd/MM/yyyy)	18/05/2017
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	23/11/2017
Were restrictive practices used?	
Does this incident involve a safeguarding concern which is alleged/confirmed?	
Has safeguarding been considered?	
Has an APP1 been completed?	
Last updated	Martina Corrigan 12/05/2017 16:14:55
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 137

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	○	○
Unlikely (Expected to occur annually)	○	◉	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○
	Grade: Low Risk				

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	consultant spoken to and importance of follow-up stressed. it was an oversight on his behalf as he was not at the meeting
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	No

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	importance of ensuring that all outcomes are actioned at end of the MDM meetings, even if not in attendance
Date investigation completed (dd/MM/yyyy)	05/12/2017
Was any person involved in the incident?	No
Was any equipment involved in the incident?	No

Notepad

Notes Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information	

Communication

Southern Health and Social Care Trust
Quality Care - for you, with you

14 August 2018 Ref: Datix: [redacted] ID: [redacted]

Private and Confidential

Mr Michael Young
Consultant Urologist

Re: [redacted]

Dear Michael

This Datix Report has been reviewed by the Surgical Adverse Incident Screening Panel, of Mr M Haynes, Mr R Carroll and Mrs T Reid on Tuesday 9th January 2018 in relation to the delay in referring [redacted] to the Endocrine Service in the Belfast Health and Social Care Trust.

On 12th January 2017 [redacted] was discussed at the Urology MDM. Please see attached Appendix 1- Urology MDM outcome.

This MDM outcome was not actioned, and on the 12th May 2017 [redacted]'s GP sent a referral letter to Urology highlighting that [redacted] had not received an appointment. On receipt of this letter a referral was then made to Endocrinology by another consultant Urologist on 18th May 2017.

The review team concluded that following MDM, any actions must be progressed by the Consultant nominated as responsible for the action required as per the MDM outcome report. Referrals for specialist care need to be sent from Consultant to Consultant.

Can you provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner?

Yours sincerely

[redacted]

Mark Haynes

Associate Medical Director

ureteric TCC. For review by Mr Haynes to discuss an early re-resection or nephroureterectomy. [redacted] underwent a re-resection TURBT and left laparoscopic nephroureterectomy for her G3 Ta urothelial cancer of the bladder and G3 distal ureteric tumour on 18th September. For pathology review and subsequent outpatient follow up with Mr Haynes. Await pathology.

MDMAction

Discussed at Urology MDM 26.09.19. [redacted] has high risk non muscle invasive bladder cancer and a muscle invasive ureteric cancer. For review by Mr Haynes to arrange a CT C/A/P in 6 months and cystoscopy in 3 months.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	None	None
[redacted]	DOB: [redacted] Age: [redacted]	CAH [redacted]	[redacted]	Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: [redacted] gentleman, previous pTa grade 3 TCC of right upper pole moiety ureter. Right upper pole moiety nephroureterectomy May 2016. pTa grade 2 TCC in prostatic cavity resected April 2017. Recurrent requiring cystodiathermy and left retrograde pyelogram August 2018. Following his recent CT requested by the colorectal team the reporting radiologist has advised that the cyst in his left kidney has increased in size from 2½ to 3cm. It has been described as Bosniak III. CT Chest, 06.08.19 - Bosniak 3 cyst centrally in the left kidney measuring 3 cm has increased since previous examination, previously 2.5 cm.

MDMAction

Discussed at Urology MDM 26.09.19. [redacted] requires an MRI scan of his kidney to further characterise the left renal cystic lesion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
[redacted]	DOB: [redacted] Age: [redacted]	DHH [redacted]	[redacted]	Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR HAYNES: [redacted] presented on the acute surgical take in Daisy Hill with abdominal pain. A CT scan showed complicated diverticular disease with a left hydronephrosis, an incidental left renal mass and an incidental lung lesion which appears to be unrelated to the renal mass. A biopsy of the lung mass has been arranged. Overall renal function is normal. For MDM review of imaging. Mr Haynes will make plans for follow up once results from lung investigations and feedback from general surgical consultant is received.

MDMAction

Discussed at Urology MDM 26.09.19. [redacted] has a left lower pole renal lesion which is suitable for surveillance given that she has recently been diagnosed with lung cancer.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	YOUNG M MR (C6861)	None	None	None
Patient 141	DOB: [redacted] Age: [redacted]	CAH [redacted]	[redacted]	Target Date

Diagnosis:
Staging:
MDMUpdate

672. Aside from the falsehood of the alleged potential concerns, it also has been repeatedly asserted that the Trust became aware of them, or that they were raised with the Trust, on Sunday 7 June 2020. The email which it was claimed gave rise to the potential concerns was sent by me at 10.25 pm. It was copied to Mr Haynes who subsequently raised the potential concerns, but he did not do so until his emailed letter to me of 11 July 2020. When I spoke with Mr Haynes by telephone on Monday 8 June 2020, he informed me that the Trust would not facilitate my return to part time employment from the 3 August 2020 as intended. He did not raise any concerns, potential or otherwise, regarding my practice during that call. In fact, he recommended that I could work in the independent sector instead. While it is possible that he had identified the potential concerns on 7 June 2020, he certainly did not raise any with me the following day.

673. Mr Haynes advised me that he was accompanied by Mr Ronan Carroll, Assistant Director of Acute Services during the telephone call. I greeted him but he did not reply. I remain uncertain whether Mr Carroll was present. If he was present, he did not raise any potential concerns with me.

674. In writing to the Minister of Health on 6 August 2020, Mr Wilson, Director of Secondary Care, referred to me as a "*retired Consultant Urologist"* and who had "*since retired from Trust employment at the end of June"* [see DOH-00686 – DOH00688]. Reference to my having retired was repeated in documentation until it was also included in the Minister's Statement on 24 November 2020 when he informed the Northern Ireland Assembly of serious concerns about *"the clinical practice of a urology consultant, Mr Aidan O'Brien, who retired from the Southern Trust earlier this year" [AOB-02973 – AOB-02979].*

675. I wish to take this opportunity to make it absolutely clear that it was never my intention to completely retire, whether on 30 June 2020 or 17 July 2020. It was my intention, after much consideration, to retire from full time employment with the Trust on 30 June 2020, and to return to part time employment from Monday 3 August 2020. I had discussed my intentions with Mr Young, Lead Clinician, with